MEDICARE CLAIMS
PROCESSING BY CARRIERS
HANDOUTS
JUN.-AUG '96

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MEDICARE PART B TRAINING

I. Part B Fee For Service Overview

- What is a "carrier"
- Specialty carriers
- Basic coverage
- Types of services processed by carriers
- Assigned/Non-assigned claims
- Claims Volume and Assignment Rates
- Participation program (enrollment, advantages)
- MEDPARD
- Medicare Charge Limits

II. Part B Fee For Service Claims

- Paper (HCFA-1500)
- Electronic (including EMC Rates)
- Other
- Claim Filing Requirements
- Time Limits for Filing Claims

III. HCFA Common Procedure Coding System (HCPCS)

IV. Fee For Service Payment Principles

- Medicare Fee Schedules
  - A. Physician Fee Schedule
  - B. Lab Fee Schedule
  - C. DME Fee Schedule
- Reasonable Charge
- Ambulatory Surgical Centers (ASCs)

CMS Library
C2-07-13
7500 Security Blvd.
Baltimore, Maryland 21244

V. Overview of Carrier Claims Processing Operations

VI. Beneficiary/Provider Payment Determination Notices

--EOMB (Bene)
--Remittance (Provider)

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What Is A Carrier ?

A carrier is an organization/entity which contracts with HCFA to process claims submitted by physicians, suppliers and other individuals/entities under the fee for service portion of the Part B program.

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Specialty Carriers

A specialty carrier handles a unique claims workload based either on the nature/type of service involved or the unique entitlement group to which the beneficiary belongs.

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SPECIALTY CARRIER SITUATIONS

- Durable Medical Equipment Regional Carriers (DMERCs)
- Railroad Retirement Board (RRB)
- United Mine Workers (UMW)
- Foreign Claims for emergency services

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MEDICARE PART B WHAT IS IT?

- Federal Health Insurance Program Which Provides Medical Insurance to Eligible Individuals
- Provides Insurance Benefits for non Hospital Type Services
- Medicare Part B Administered Locally By:
  - **Carriers**: Fee-for-service Insurance Type Organizations (I.e., Blue Shield, Aetna, Transamerica
  - **Specialty Carrier**: "Carriers" Processing Specific Type of Medicare Part B Claims (i.e., DMERC)
  - **HMOs**: non Fee-for-service Type of Organizations, "Managing" Complete Care of Beneficiary (i.e., Secure Horizons, PacifiCare, Etc.)

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PART B BASIC COVERAGE

- MEDICAL INSURANCE FOR:

  - **People 65 years** or older and eligible for Social Security Benefits or Railroad Retirement Benefits
    - Eligible the first day of the month in which individual becomes 65.
    - Age 65 attained on the day before the 65th birthday.

      EXAMPLE - An individual born on December 1 attains age 65 on November 30. Medicare effective on November 1

  - **Disabled Insureds**: Individuals who are disabled and are entitled to Social Security benefits or railroad retirement Benefits are entitled to Medicare coverage.
    - Entitlement begins after the individual disabled for a total of 29 months
    - If bene recovers and has not attained age 65, entitlement ends in the month following notification to Medicare of disability termination.

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PART B BASIC COVERAGE

- MEDICAL INSURANCE FOR:

- **<u>End Stage Renal Disease (ESRD) Insureds</u>;**

  - Individuals receiving dialysis or renal transplantation
  - Spouses or dependent children of disabled
  - Coverage begins three months after course of renal dialysis begins, Exception:
    (1) Kidney transplant
    (2) Participation in a self dialysis training program

  - Coverage ends:
    1. The day the beneficiary dies
    2. After dialysis is discontinued
    3. After kidney transplant

- Anyone qualified for Medicare Part A is automatically entitled to Medicare Part B

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BASIC COVERAGE

Medicare Part B Premium:

- Annually set by the DHHS, announced by the DHHS Secretary

- Paid monthly via one of five methods:

1. Direct Deduction
2. State Buy-in program
3. Beneficiary Billing
4. Third Party
5. Low Income program

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MEDICARE PART B DEDUCTIBLES

(Refer To Handout At Back of Package)

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MEDICARE PART B DEDUCTIBLES

- Annual Monetary Deductible
- Annual Blood Deductible

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TRIVIA

? *Can an individual qualified for Medicare under the entitlement rules be excluded from coverage due to a criminal conviction?*

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TYPE OF COVERED SERVICES

(Also known as Benefit Categories)

* See Medicare Handbook for a complete listing of covered and non-covered services.

- **Physician Services**: Inpatient & outpatient services for the time/skill actually spent with the physician

- **Durable Medical Equipment**: wheelchairs, walkers, beds, commodes, canes, etc.

- **PEN** (Parenteral Enteral Nutrition):
  - Liquid nutrition for those individuals not able to receive "food" via mouth
  - Provided via canned supplement (Ensure) and other methods such as internal feeding tubes such as nasal tubing.
  - Extremely expensive

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TYPE OF COVERED SERVICES

- Home Health Services (i.e., in-home Hospice Care, part time intermittent skilled nursing care) when bene not covered under Medicare Part A

  Home Health Care covered when ALL four of the following conditions met"

  1. The required care includes intermittent skilled nursing care, physical therapy, or speech therapy;

  2. Bene confined to home;

  3. Bene under care of physician who determines Home Health Care is needed and established treatment plan;

  4. Home Health Agency participates in the Medicare program.

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TYPE OF COVERED SERVICES

- Hospice Care covered when ALL three of the following conditions are met.

1. Beneficiary certified to be terminally ill;
2. Beneficiary chooses Hospice for care;
3. Hospice participates in Medicare program.

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TYPE OF COVERED SERVICES

- Ambulance Services
- Radiological and Pathological Tests
- Non Routine Dental care
- Non Routine Foot care
- Blood Replacement
- Chiropractor manipulation of the spine
- Many Other, see Medicare Handbook for more complete list.

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TYPE OF SERVICES NOT COVERED

(Statuatory Exclusions)

* See Medicare Handbook for a complete listing of covered and non-covered services.

- Routine physical exams and related tests
- Eye and ear exams
- Most Immunizations
- Cosmetic surgery
- Services outside of the U.S.

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TYPE OF SERVICES NOT COVERED

- Routine foot care
- Most prescription drugs
- Non FDA approved drugs
- ~~Investigational devices~~ - Recent legislation now allows for payment
- Routine dental services
- Services which are not deemed reasonable or medically necessary.
  - National policies exist but local carriers also have discretion to develop policy.

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Assigned/Nonassigned Claims

- Typically, the two (2) types of Part B claims submitted to carriers for payment are:
  - Assigned claims
  - Non-assigned claims

- Characteristics of **assigned** claims:
  - Medicare payment is made directly to the service provider (i.e., the physician or supplier);
  - The provider agrees to accept Medicare's allowed amount as payment in full for the service provided (i.e., the provider may not collect from or bill the beneficiary for the difference between the billed amount and the Medicare allowed amount).

- Characteristics of **non-assigned** claims:
  - Medicare payment is made to the beneficiary;
  - The provider may collect the billed amount from the beneficiary (provided that amount does not exceed Medicare statutory charge limits).

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Mandatory Assignment

- Services that can only be paid on an "assigned" basis
  - Clinical diagnostic lab tests
  - Physicians services provided to Medicare beneficiaries who are also Medicaid recipients (dual eligibles)
  - Services furnished by certain practitioners who must always accept assignment:
    - Certified Registered Nurse Anesthetists (CRNAs)
    - Certified Nurse Midwife
    - Clinical Psychologist
    - Clinical Social Worker
    - Physician Assistant
    - Nurse Practitioner
    - Clinical Nurse Specialist
  - Services furnished by "participating" physicians and suppliers
  - Ambulatory Surgical Center (ASC) facility charges for covered ASC procedures.

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Examples

Claim Type	Billed Amount	Medicare Approved	Medicare Paid	Beneficiary Liability
Assigned	$115	$100	$80	$20
Assigned	$460	$400	$320	????
Assigned	$590	$520	????	????
Nonassigned	$115	$100	$80	$35
Nonassigned	$460	$400	$320	????
Nonassigned	$590	$520	????	????

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Examples - Answers

Claim Type	Billed Amount	Medicare Approved	Medicare Paid	Beneficiary Liability
Assigned	$115	$100	$80	$20
Assigned	$460	$400	$320	???? $80
Assigned	$590	$520	$416 ????	$104 ????
Nonassigned	$115	$100	$80	$35
Nonassigned	$460	$400	$320	$140 ????
Nonassigned	$590	$520	$416 ????	$174 ????

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Medicare Participation

Q. What does it mean to be a "participating" physician/supplier ?

A. A participating physician or supplier voluntarily enters into an agreement to always accept assignment for covered Part B services furnished to their Medicare patients during the calendar year for which the participation agreement applies.

Q. What are the advantages of participating ?

A. Physicians who participate enjoy the following benefits:

- Medicare Physician Fee Schedule allowances are 5 percent higher than those of nonparticipating physicians;
- Participating physicians are not subject to limits on actual charges which do apply to nonassigned claims of nonparticipating physicians;
- Participants are listed in directories of participating physicians and suppliers (MEDPARD) published by Medicare carriers;
- If they bill electronically, participants are provided toll free claims transmission lines
- Medicare payment information is automatically forwarded to Medigap insurers for beneficiaries who assign their Medigap payment to the physician/supplier.

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Participation Enrollment

- Annual enrollment/disenrollment (generally runs from November 15 through December 31 each year)
- Participation period generally runs from January 1 through December 31. (New providers are afforded the opportunity to enroll when they apply for a billing number.)
- Once a physician/supplier elects to "participate', the participation agreement automatically renews each year until the provider formally disenrolls
- Can only disenroll during a general enrollment period (effective Jan 1 of the upcoming year)

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Participation Statistics

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MEDICARE CHARGE LIMITS

- Although a nonparticipating physician doesn't have to accept assignment, for most covered services there are limits on the amount the physician can actually charge.

- Effective January 1, 1993, nonparticipating physicians and others who submit claims for services paid under the physician Fee Schedule cannot charge Medicare patients amounts that exceed 115 percent of the non-par fee schedule amount for a covered service.

- Nonparticipating doctors and others who charge more than the Medicare charge limits can be fined/sanctioned.

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QUIZ

T F Medicare participating physicians and suppliers agree to submit all Part B covered services as "assigned" claims.

T F Nonparticipating physicians and suppliers cannot submit assigned Medicare claims

T F Participating physicians and suppliers need to sign and submit a new participation agreement every year during the annual participation enrollment process

T F There are no limits on what a participating physician can charge a Medicare patient

T F When a claim is "assigned" the Medicare payment goes directly to the physician/supplier rather than the beneficiary

T F One benefit of "participation" for physicians is that their Medicare approved amount is 5 percent higher than that of a nonparticipating physician

T F If the nonparticipating physician fee schedule amount is $120, the Medicare charge limit is $138

T F If the participating physician fee schedule amount is $300, the nonparticipating physician fee schedule amount is $285.

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QUIZ – Answers

(T) F Medicare participating physicians and suppliers agree to submit all Part B covered services as "assigned" claims.

T (F) Nonparticipating physicians and suppliers cannot submit assigned Medicare claims

T (F) Participating physicians and suppliers need to sign and submit a new participation agreement every year during the annual participation enrollment process

(T) F There are no limits on what a participating physician can charge a Medicare patient (There are limits on how much can be collected on assigned services)

(T) F When a claim is "assigned" the Medicare payment goes directly to the physician/supplier rather than the beneficiary

(T) F One benefit of "participation" for physicians is that their Medicare approved amount is 5 percent higher than that of a nonparticipating physician

(T) F If the nonparticipating physician fee schedule amount is $120, the Medicare charge limit is $138

(T) F If the participating physician fee schedule amount is $300, the nonparticipating physician fee schedule amount is $285. What is the Medicare charge limit? $ 327.75

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TYPES OF CLAIM SUBMISSIONS

- Paper Claims (average of 21%):
  - HCFA 1490 forms are submitted by the beneficiary.
  - HCFA 1500 forms are submitted by the provider.

EMC/EDI CLAIMS (Average of 79%)

- Magnetic Claims:
  - These claim requests are submitted on a reel and processed directly in our system.

- Dial-Up:
  - These claims are called into our office for processing.

- Electronic Claims:
  These claims are transmitted electronically by the physician using a personal computer, directly into the carrier's Medicare System

- Diskettes:
  Claims are transferred to the carrier via **diskette**

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PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other

Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES | NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authonze payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPU

PHYSICIAN OR SUPPLIER INFORMATION

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ELECTRONIC CLAIM FACSIMILE

DATE: 03-28-96

SUBMITTER CODE: 000001546

CMA IND: ASSIGNMENT INDICATOR A

PRIVACY IND: Y

RX DATE 1: RX LENGTH 1:
RX DATE 2: RX LENGTH 2:
RX DATE 3: RX LENGTH 3:

ELG SUP NAME: SANSUM MEDICAL CLINIC
ELG SUP ADDR: 317 W PUEBLO STREET
ELG SUP CITY: S BARBARA 93102

PRF SUP 1:
PRF SUP ADDR:
PRF SUP CITY:

PRF SUP 2:
PRF SUP ADDR:
PRF SUP CITY:

HIC NO.: 572-20-8854-A
MEDI-CAL NO:

BENE NAME: PICKETT , VINCENT R
BENE ADDR: 22 W CONSTANCE AVE 2F
BENE CITY: SANTA BARBARA BENE STATE: CA BENE ZIP: 93105

REF PAY IND: TAR NO:
REF NAME:
REF ADDR:
REF CITY: REF STATE: REF ZIP:

CHANGE OF ADDRESS IND:
ACCIDENT IND: N SEC.INS.IND: PRE AUTHORIZATION:

DIAG 1: 5921 MEDIGAP IND:
DIAG 2: 5920 MEDIGAP ASSIGNMENT IND:
DIAG 3: MEDIGAP POLICY NO:
DIAG 4: MEDIGAP NAME:
MVMO#: MEDIGAP IDENTIFIER:
LAST SEEN: MEDIGAP ADDRESS:
HOMEBOUND: MEDIGAP CITY:
MEDIGAP STATE ZIP:

SUPPLEMENTAL INS. IND: I

DEATH IND: N
DATE OF BIRTH: 01-30-13
KARNOFSKY SCALE:
SEX: M

LNE NO	DATES	POS	TOS	ORIG PROC	ORIG M1 M2	DIAG 1	DX 2	DX	NO SVC	ELG SUP CHARGE	ELG SUP CODE	ACT ACQ CHARGE	PRF SUP CODE	REND PHYS CODE	SP IND	DME IND
01	03-01 03-01-96	21	02	52336		1			001	715.10	W226	0.00		WG63522B	0	0
02	03-01 03-01-96	21	02	52332		1			001	272.81	W226	0.00		WG63522B	0	0
03	03-06 03-06-96	22	02	50590	YB	2			001	887.47	W226	0.00		WG63522B	0	0

TOTAL CHARGES: 1875.38 AMT PAID BY BENE: 0.00

LINE COMMENTS
NO
01 CR MANIPULATION OF CALCULUS

E NO	REF PHYS CODE	REF PHY NAME	FAC NAME
01	E55359	CURHAN	SANTA BARBARA COTTAG
02	E55359	CURHAN	SANTA BARBARA COTTAG
03	E55359	CURHAN	SANTA BARBARA COTTAG

Mandatory Claims Submission

- Effective September 1, 1990
- Requires all physicians and suppliers who furnish covered Part B services to submit bills to carriers on behalf of beneficiaries
- Claims must be submitted within one year of the date of service
- Medicare payment on "assigned" services is reduced 10 percent if a claim is not submitted within one year
- Physicians/suppliers can be sanctioned for not submitting claims timely

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Time Limits for Filing Claims

- In order for payment to be made for a covered Part B service a claim must be filed timely

- Medicare law requires a claim be filed no later than the end of the calendar year following the year in which the service was furnished

  - EXCEPTION: For services furnished during the last three months of the calendar year, the time limit is extended through December 31 of the second year following the date of service

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Time Limit Examples

Date of Service	Claim Filing Expiration Date
06/18/96	12/31/97
09/01/97	12/31/98
11/15/96	12/31/98
09/30/96	??????????
10/01/96	??????????
12/31/97	??????????
01/01/98	??????????

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EXAMPLES – Answers

Date of Service	Claim Filing Expiration Date
06/18/96	12/31/97
09/01/97	12/31/98
11/15/96	12/31/98
09/30/96	????????? 12/31/97
10/01/96	????????? 12/31/98
12/31/97	????????? 12/31/99
01/01/98	????????? 12/31/99

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Procedure Codes and Modifiers

- In the mid-1980s the Health Care Financing Administration Common Procedure Coding System (HCPCS) became the official coding system used by all Medicare carriers for processing Part B claims

- HCPCS consists of three levels of procedure codes

  - Level 1--CPT-4 Codes:
  - developed/maintained by the American Medical Association -five digit numeric codes (e.g., 90020, 75553, 30020, etc.)
  - national usage

  - Level 2--HCFA alpha codes
  - developed/maintained by HCFA
  - five digits beginning with alpha A through V plus numerics
  - national usage

  - Level 3--Carrier local codes
  - developed/maintained by local carriers
  - HCFA prior approval required
  - five digits beginning with alpha W, X, Y or Z plus numerics
  - used only within service area of assigning carrier

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E X E R C I S E

Indicate whether the following are CPT, HCFA-assigned or local codes by entering either a 1 (CPT), 2 (HCFA-assigned), 3 (local) or 4 (other) next to the code:

_____ 90020

_____ 77542

_____ R0075

_____ 55036

_____ E0184

_____ 20984

_____ Z0069

_____ 6Z3A4

_____ W6984

_____ A2200

_____ X1009

_____ 30032

_____ J4100

_____ Y3500

_____ V4102

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E X E R C I S E

Answers

Indicate whether the following are CPT, HCFA-assigned or local codes by entering either a 1 (CPT), 2 (HCFA-assigned), 3 (local) or 4 (other) next to the code:

1	90020	3	W6984
1	77542	2	A2200
2	R0075	3	X1009
1	55036	1	30032
2	E0184	2	J4100
1	20984	3	Y3500
3	Z0069	2	V4102
4	6Z3A4		

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Payment Floors/Ceilings

Payment Floors: a payment waiting period beginning with the day after a claim is received. Medicare payment for approved services cannot be issued until the applicable payment floor has elapsed.

For claims received on or after 10/01/93, the payment floors are:

- o 13 days (electronic claims)
- o 26 days (paper claims)

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Payment Ceiling: The period of elapsed time after which interest is payable for "clean claim" covered services that have not been finally adjudicated for payment.

- As of 10/01/93, the payment ceiling standard for both paper and electronic clean claims is 30 days.

- Interest is payable for the number of days in excess of thirty that are required to finally adjudicate a clean claim.

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FEE FOR SERVICE PAYMENT PRINCIPLES

- Medicare Part B approved amounts are now, for the most part, based on fee schedules;
- The approved amount is the lower of the actual charge or the Medicare fee schedule amount;
- Medicare payments are usually 80 percent of the approved amount

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Medicare Fee Schedules

- Physician Fee Schedule
- DME Fee Schedule
- Clinical Diagnostic Lab

Medicare fee schedules are updated annually

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Physician Fee Schedule

- Effective January 1, 1992
- Applies to physician and other services formerly paid under reasonable charge:
  - professional services
  - supplies and services incident to physicians' services
  - outpatient physical and occupational therapy
  - diagnostic tests (other than clinical lab)
  - radiology services

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In 1989, Congress enacted OBRA legislation which replaced the existing Medicare "reasonable charge" payment methodology for physicians services with a Physician Fee Schedule effective 1/1/92.

Under the Physician Fee Schedule, the amount approved for each covered service represents the resources that go into providing that service, relative to all other services on the fee schedule.

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Physician Fee Schedule amounts are a product of three numbers:

1. Relative value units (RVUs)for:
   --professional work (RVUw),
   --practice expenses (RVUpe),
   --malpractice (RVUm)

2. A geographic practice cost index (GPCI) for:
   --professional work (GPCIw)
   --practice expenses (GPCIpe)
   --malpractice (GPCIm)

3. A conversion factor (CF) which translates the RVU and GPCI values into dollar amounts

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The Medicare fee schedule amount for a given service is computed using the following formula:

[(RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm)] x CF = Fee Schedule Amount

Example

To compute the payment amount for biopsy of skin lesion (CPT code 11100) in Birmingham, Alabama in 1996, use the following RVUs for work, practice expense, and malpractice:

Work RVU (RVUw) = 0.81
Practice expense RVU (RVUpe) = 0.51
Malpractice RVU (RVUm) = 0.04

Next, use the GPCI values for work, practice expense, and malpractice for Birmingham:

Work GPCI (GPCIw) = 0.994
Practice expense GPCI (GPCIpe) = 0.912
Malpractice GPCI (GPCIm) = 0.927

Finally, using $40.7986 as the uniform national CF, place the values into the formula provided and compute:

Payment = (RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm) x CF
Payment = (0.81 x 0.994) + (0.51 x 0.912) + (0.04 x .927) x 40.7986
Payment = (0.81) + (0.47) + (0.04) x 40.7986
Payment = (1.32) x 40.7986
Payment = $53.85 (Full Fee Schedule Payment)

Round fee schedule amounts to the nearest cent.

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DME Fee Schedule

- Effective January 1, 1989, fee schedules replaced reasonable charge pricing for DME
- Medicare approved amount is limited to the lower of the actual charge or the DME fee schedule amount
- Equipment is grouped into six classes for payment purposes:
  - Inexpensive/routinely purchased DME
  - Items requiring frequent/substantial servicing
  - Customized items
  - Prosthetic/orthotic devices
  - Capped rental items
  - Oxygen/oxygen equipment

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Clinical Diagnostic Lab Tests

- Effective July 1, 1984 clinical diagnostic lab tests performed in a physician's office or by an independent laboratory, or by a hospital lab for outpatients are paid on the basis of fee schedules

- Must be billed as "assigned"

- Payment is 100 percent (no coinsurance) of the Medicare approved amount

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Reasonable Charge Pricing

- Under reasonable charge rules, the Medicare approved amount is the lowest of:
- Actual Charge
- Customary Charge
  - Provider specific
- Prevailing charge
  - Locality specific

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Customary Charge Exercises

Calculate each suppliers customary charge based on the following arrays of charges:

Supplier #1	Supplier #2	Supplier #3
$20	$25	$32
$22	$26	$32
$25	$29	$33
$26	$31	$33
$30	$31	$33
	$32	$35
	$35	$35
		$37
		$39
		$40
		$40

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Customary Charge Exercises - Answers

Calculate each suppliers customary charge based on the following arrays of charges:

Supplier #1	Supplier #2	Supplier #3
$20	$25	$32
$22	$26	$32
$25	$29	$33
$26	$31	$33
$30	$31	$33
	$32	$35
	$35	$35
		$37
		$39
		$40
		$40

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Prevailing Charge Exercise

Note: Step #1 has already been performed for you

Supplier	Customary	Frequency	Cumulative Frequencies
#1	$20	10	10
#2	$23	14	24
#3	$25	16	40
#4	$25	20	60
#5	$27	19	79
#6	$29	13	92
#7	$30	8	100

Step 1--Array the "weighted" customary charges for each supplier

Step 2--Determine where the 75th percentile of the arrayed, weighted customary charges falls

Step 3--Determine which suppliers customary charge encompasses the 75th percentile of arrayed/weighted customary charges.

Step 4--yell "bingo" once you have successfully completed step 3

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Prevailing Charge Exercise – Answer

Note: Step #1 has already been performed for you

Supplier	Customary	Frequency	Cumulative Frequencies
#1	$20	10	10
#2	$23	14	24
#3	$25	16	40
#4	$25	20	60
#5	$27	19	79
#6	$29	13	92
#7	$30	8	100

Step 1--Array the "weighted" customary charges for each supplier

Step 2--Determine where the 75th percentile of the arrayed, weighted customary charges falls

Step 3--Determine which suppliers customary charge encompasses the 75th percentile of arrayed/weighted customary charges.

Step 4--yell "bingo" once you have successfully completed step 3

Prevailing charge = $27

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Ambulatory Surgical Centers (ASCs)

- Payments are based on 8 group rates for covered procedures

Group	**Base Rate** (effective 10/1/95)
1	$304
2	$408
3	$467
4	$576
5	$657
6	$769
7	$911
8	$903

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MEDICARE CLAIMS FLOW

- **Mailroom (Paper Claims)**
  - Opens all Medicare mail--(claims and correspondence)
  - Counts and prepares claims by batches
  - Assigns internal control number to each claim
  - Claims and attachments are microfilmed

- **Medicare Claims Adjudication**
  - Data entry of claim details
  - If necessary, develops to provider and/or beneficiary for additional information.

- **Medicare Claims Review**
  - Reviews services exceeding frequency parameters
  - Reviews services for medical necessity requirements
  - Reviews duplication of services
  - Medical Directors review claims with extenuating circumstances and/or medical documentation.
  - Reviews services for other edit (e.g., place of service, charges, provider id

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- **Medicare Post Payment Review**
  - Reviews all written and telephone requests for reviews and reopenings of claims
  - Determines if corrective action is required and/or provides an explanation of Medicare payment policies
  - Responds to written claim status and general information inquiries.

- **Fair Hearings**
  - Provides hearings to Medicare claimants (i.e., beneficiaries, physicians, suppliers, and other concerned individuals)
  - Determines the accuracy of the claim's original processing and review process
  - Applies all of the Medicare Law, regulations and guidelines for each claim in dispute

- **Medicare Beneficiary and Physician Services**
  - Responds to telephone inquiries from beneficiaries, physicians, and suppliers.
  - Handles walk-in inquiries from beneficiaries, physicians and suppliers
  - Responds to all congressional inquiries.

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SOURCES OF ADDITIONAL INFORMATION

- Medicare Handbook
- HCFA's Internet WEB Site
- HCFA CD-ROM collection of Medicare, Medicaid Laws, Rules, Regulations, etc.

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HCFA MEDICARE/MEDICAID

THE MEDICARE/MEDICAID AGENCY

MEDICARE INFORMATION

A primary function of HCFA is the administration of Medicare. Medicare covers approximately 37 million Americans age 65 and over and those who have permanent kidney failure and certain people with disabilities.

- ☐ OVERVIEW of the Medicare and Medicaid Programs
- ☐ The Medicare Transaction System (MTS)

  The MTS Operating Site Request for Proposals April 25, 1996
  1. whol1rfp.zip The RFP in WordPerfect 6.1 Format 209,528 Bytes
  2. whol2rfp.zip Section J attachments to MTS Operating Site RFP (zipped file containing WordPerfect and Excel files 2,977,793 Bytes)
  3. wholerfp.pdf The RFP in Adobe Acrobat Format 1,171,227
  4. wholerfp.zip The RFP in WordPerfect 5.1 Format 180,828 Bytes
- ☐ QUALITY OF CARE Information
  Peer Review, End Stage Renal Disease, State Survey Progran, CLIA
- ☐ MANAGED CARE INFORMATION
- ☐ PROVIDER/SUPPLIER ENROLLMENT Information
- ☐ The MEDICARE 1995 HANDBOOK
  --- Part A Hospital Insurance --- Part B Medical Insurance
- ☐ 1995 GUIDE to Health Insurance for People with Medicare
- ☐ MEDIGAP for the disabled at age 65
- ☐ A basic PAMPHLET on the Medicare program

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DEDUCTIBLES

- Annual Monetary Deductible

- The amount the beneficiary owes before Medicare medical insurance starts paying for their medical expenses each calendar year (January 1 through December 31) Is applied to the first approved-for-payment claims in each calendar year. Is $100.00 each year for 1994 and 1996

  EXAMPLE: If a service was performed in December of 1995 and the claim finalized in January, 1996, any deductible applied would be for the 1995 calendar year.

- The deductible can only be satisfied from approved services processed by a Medicare Part B carrier or Part A Intermediary when processing Part B services.

- Part B services processed by Part A may include but are not limited to:
  Emergency Room Services.
  X-rays and other Radiology Services.
  Anatomical Laboratory Tests.

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- All carriers forward records of any deductible amounts to be applied to the site which houses the beneficiary's Common Working File (CWF) record. All deductible records of individual beneficiaries remain on their files. Therefore, it does not matter in which state or states the deductible is applied.

- All beneficiaries are responsible for payment to the provider of services for all monies applied toward their annual deductible withheld from Part B processed claims. If the beneficiary has another insurance which pays the Medicare Part B deductible, it is the beneficiary's responsibility to contact that insurance office.

- The physician can request payment for the beneficiary's deductible at the time the services are performed, even if they have other insurance which may pay their deductible.

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PROVIDER DEFINITIONS

PHYSICIAN (MD OR DO)

Individual who has successfully completed the prescribed course of studies in medicine in a medical school which is recognized by the country in which it is located. Also, the qualifications for licensure in the practice of medicine must be satisfied.

- Must successfully complete 4 years of undergraduate study.
- Must successfully complete 4 years of Medical School.
- Specialty determines length of additional training.
- Must successfully pass a State Board examination.

PHYSICIAN ASSISTANT

Individual trained and licensed to perform, under supervision, some of the physician's duties.

- Must meet the applicable State requirements.
- Provide services which traditionally have been reserved for physicians
- Can give injections, change dressings, perform physical examinations, assist in major surgery, set casts for simple fractures, and interpret x-rays.

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PSYCHIATRIST

A physician (MD) who specializes in the study, diagnosis, treatment and prevention of mental disorders.

- Certain outpatient mental health treatments are subject to a 62.5% reduction.
- Diagnostic services, psychiatric testing and evaluation to diagnose the patient's illness are not subject to the 62.5% reduction.
- Inpatient services are also not subject to the 62.5% reduction.

PSYCHOLOGIST (CLINICAL)

An individual who holds a Ph.D. in the science of mental processes and behavior.

- Can perform both diagnostic and therapeutic services.
- Therapeutic services only are subject to the 62.5% reduction.

PSYCHOLOGIST (INDEPENDENT PRACTICING)

An individual who holds a Ph.D. in the science of mental processes and behavior.

- Can perform diagnostic testing only.
- Testing must be ordered by a physician.
- Diagnostic services are not subject to the 62.5% reduction.

CLINICAL SOCIAL WORKER

An individual who directs social services to patients and family in conjunction with other members of the health care team. A primary focus is to assist in counseling and management of the social and emotional factors relating to illness.

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- Can perform diagnostic and therapeutic services connected with mental illness.
- Therapeutic services are subject to the 62.5% reduction.
- Diagnostic services are not subject to the 62.5% reduction.

PHYSICAL THERAPIST

A licensed therapist who is responsible for planning, conducting and evaluating a physical therapy program for patients referred by a physician.

- Must be licensed and Medicare certified.
- Must have an independent practice.
- Must render services in physical therapist own office or the patient's home.
- Must have "Plan of Treatment" on file for beneficiary

CHIROPRACTOR (D.C.)

An individual certified and licensed to treat diseases by manipulation of the spine.

- Reimbursement limited to manipulation of the spine, either manually or by use of an activator.
- Not permitted to prescribe Medications.

Podiatrist (D.P.M)

A health professional responsible for the examination, diagnosis, prevention, treatment and care of conditions and functions of the human foot.

- Can treat local manifestation of a systemic disease.

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- Can NOT treat the systemic disease itself.
- Can perform limited surgery.

AMBULANCE

A vehicle for the transportation of the sick and injured, equipped and staffed to provide medical care during transit.

- Must meet certain HCFA, state and local requirements to provide emergency medical services to Medicare beneficiaries.
- Certain services must be sent to Medicare Part A for processing.
- Basic Life Support (BLS)
- Advanced Life Support (ALS)
- Air Ambulance

ANESTHETIST

Individual who administers anesthetics, especially for general anesthesia. May be a specially trained physician or nurse.

- Physician can personally administer anesthesia or direct a qualified anesthetist.

OUTPATIENT HOSPITAL

Services received at a hospital, clinic or dispensary without the patient being hospitalized.

- Short Procedures
- Emergency Services

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- Radiology
- Mental Health Services

SITE OF SERVICE (S0S)

Certain office-based services performed in a hospital outpatient or inpatient setting.

- Applicable to specific places of service.
- Outpatient Hospital
- Emergency Room Hospital
- Comprehensive Outpatient Rehabilitation Facility
- End Stage Renal Disease Treatment Facility
- Inpatient Hospital
- Inpatient Psychiatric Facility
- Can include office and confirmatory consultations.
- Reduction in payment may occur.

INDEPENDENT PHYSIOLOGICAL LAB (IPL)

Physiological services furnished by laboratories which operate independent of a hospital, physician's office, or a rural health clinic and comply with specific guidelines for procedures performed.

- Diagnostic procedures performed which measure body functions and are non-invasive.
- Ultrasound

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- Magnetic Resonance Imaging (MRI)
- Tracing of Telephone Transmission of Electrocardiogram Rhythm strips.
- Must be ordered by the patient's physician.

RADIOLOGIST

A physician who specializes in the use of x-rays and radioactive substances, both for diagnostic and for treating disease.

CLINICAL LABORATORY

Facilities which analyze laboratory tests.

- Must meet specific certification requirements (CLIA)
- Urine
- Blood

CERTIFIED REGISTERED NURSE ANESTHETIST

A registered nurse who has successfully completed and graduated from an accredited Nurse Anesthetist program.

- Can be medically directed
- Can be nonmedically directed, (perform procedure without assistance from an anesthesiologist)
- Procedures are limited by State Law

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AMBULATORY SURGICAL CENTERS

Free standing facilities operating exclusively for the purpose of providing outpatient surgical services.

a)

- Must be State Certified
- Reimbursement subject to specific guidelines

SUPPLIERS

Any entity that provides durable medical equipment, prosthetics, orthotics and medical supplies to Medicare beneficiaries.

- Wheelchairs
- Walkers
- Glucometers and test strips
- Glasses after cataract surgery

AUDIOLOGIST

A specialist in the evaluation, habilitation, and rehabilitation of persons with hearing disfunctions.

- Diagnostic testing to determine if medical or surgical treatment is needed.
- Physician must order the diagnostic testing

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CARRIER	ASSIGN RATE	RATIO PROC/ REC'D	CLAIMS RECEIVED VIA ELECTRONIC MEDIA — TOTAL NUMBER	TOTAL PERCENT OF TOTAL CLMS RECEIVED	ASSIGNED PERCENT OF ASS'D. CLAIMS RECEIVED	UNASSIGNED PERCENT OF UNASS'D CLAIMS RECEIVED	REPLICATE CLAIMS PERCENT OF TOTAL CLMS PROCESSED	CLAIMS INVEST RATE
NATIONAL TOTAL	95.9	101.1	46,529,138	78.3	79.4	50.5	0.6	1.5
BOSTON REGION	98.3	98.2	2,648,575	82.1	82.7	46.5	0.1	1.6
CONNECTICUT-METRAHEALTH	96.4	96.4	709,676	81.6	82.6	55.0	0.1	4.6
MASSACHUSETTS B/S	98.9	98.6	1,711,058	82.1	82.6	34.3	0.0	0.5
MASSACHUSETTS	99.5	99.7	1,240,945	84.0	84.2	28.5	0.0 *	0.5
TRI-STATE	97.3	96.0	470,113	77.5	78.6	36.8	0.1	0.5
MAINE	98.6	97.6	206,138	75.0	75.6	32.5	0.1	0.6
NEW HAMPSHIRE	95.[illegible]	93.6	190,331	79.4	81.3	37.1	0.0 *	0.5
VERMONT	97.7	97.8	73,644	79.8	80.6	43.6	0.0 *	0.5
RHODE ISLAND B/S	99.6	100.8	227,841	83.7	83.7	63.8	0.1	0.1
NEW YORK REGION	96.0	97.6	3,779,041	75.7	77.0	44.7	0.1	1.4
N.Y.-WESTERN NY B/S	96.0	97.2	1,046,722	80.4	81.9	45.6	0.1	0.9
N.Y.-EMPIRE B/S	95.1	96.6	2,083,300	77.2	78.9	45.8	0.2	1.9
NEW YORK-GROUP HEALTH	96.6	100.9	265,707	79.6	81.0	42.1	0.1	0.2
TRIPLE-S, INC.	99.4	100.5	383,312	57.9	58.3	6.0	0.1	0.7
PUERTO RICO	99.5	100.4	383,205	58.1	58.4	5.7	0.1	0.7
VIRGIN ISLANDS	70.4	130.9	107	6.0	5.1	8.1	0.3	2.9
PHILADELPHIA REGION	96.6	102.5	6,468,883	78.0	79.3	42.3	0.2	1.8
PENNSYLVANIA B/S	96.8	102.2	5,153,164	77.8	79.0	41.9	0.2	1.1
DELAWARE	96.2	106.2	142,222	79.6	80.9	46.5	0.2	1.1
DISTRICT OF COLUMBIA	95.8	101.1	413,563	69.2	70.6	38.2	0.3	1.5
NEW JERSEY	92.9	104.2	1,616,002	76.1	78.5	43.7	0.3	1.3
PENNSYLVANIA	99.0	102.3	2,460,899	76.8	77.3	35.0	0.2	1.0
PENNSYLVANIA-LAB.	100.0	92.4	520,478	99.9	99.9	0.0	0.0 *	0.7
VIRGINIA-METRAHEALTH	97.5	102.4	812,449	80.7	81.4	53.9	0.1	5.7
DMERC-METRAHEALTH	93.4	106.1	503,270	76.6	79.3	37.7	0.2	2.5
ATLANTA REGION	96.4	103.8	9,480,333	78.5	79.4	52.4	0.7	1.4
ALABAMA B/S	98.3	107.7	772,373	85.1	85.5	61.7	0.1	0.8
FLORIDA B/S	97.2	108.3	3,657,402	80.7	81.4	56.9	1.3	2.5
GEORGIA-AETNA	96.8	92.1	1,046,842	73.4	74.2	50.9	1.2	1.2
KENTUCKY B/S	97.1	99.5	802,975	77.2	78.0	50.2	0.1	0.4
MISSISSIPPI-METRAHEALTH	96.9	96.6	446,246	81.2	81.7	63.3	0.2	1.3
NO. CAROLINA-CONN GEN	92.9	105.1	1,327,697	75.7	78.1	44.9	0.1	0.3

* - LESS THAN 0.05 %

CARRIER	ASSIGN RATE	RATIO PROC/ REC'D	CLAIMS RECEIVED VIA ELECTRONIC MEDIA				REPLICATE CLAIMS	
			TOTAL		ASSIGNED	UNASSIGNED		
			NUMBER	PERCENT OF TOTAL CLMS RECEIVED	PERCENT OF ASS'D. CLAIMS RECEIVED	PERCENT OF UNASS'D CLAIMS RECEIVED	PERCENT OF TOTAL CLMS PROCESSED	CLAIMS INVEST RATE
SOUTH CAROLINA-PGBA	94.8	104.1	524,833	80.1	81.2	59.6	0.0 *	1.0
TENNESSEE-CONN GEN.	96.9	102.5	901,965	74.2	74.9	50.4	0.1	0.3
CHICAGO REGION	96.0	101.2	9,535,160	84.5	85.6	56.7	0.1	1.2
ILLINOIS B/S (HCSC)	94.0	101.7	1,887,864	83.3	84.9	57.7	0.2	0.4
INDIANA B/S	94.3	103.8	868,482	78.4	80.1	50.8	0.1	0.5
MICHIGAN-HCSC	98.0	100.7	2,224,015	92.5	93.0	68.0	0.1	0.2
MINNESOTA B/S	0.0	0.0	NIF	0.0	0.0	0.0	0.0	0.0
MINNESOTA-METRAHEALTH	93.2	101.6	579,641	84.3	84.4	82.5	0.1	14.7
NATIONWIDE	98.9	101.6	2,641,697	84.9	85.5	25.4	0.1	0.1
OHIO	99.0	101.6	2,318,755	85.9	86.5	22.7	0.1	0.1
WEST VIRGINIA	98.3	101.5	322,942	78.2	79.0	35.4	0.1	0.1
WISCONSIN PHY. SER.	94.4	98.0	770,709	79.2	80.0	66.3	0.1	1.4
DMERC-INDIANA B/S	91.5	99.2	562,752	76.7	80.1	40.9	0.2	0.4
DALLAS REGION	95.4	99.9	5,846,569	80.1	81.8	43.8	0.1	2.6
ARKANSAS B/S	97.5	103.4	427,593	83.1	83.8	56.7	0.0 *	2.1
LA.-ARKANSAS B/S	97.1	103.4	692,127	81.7	83.0	38.9	0.1	1.6
NEW MEX.-OKLA.-AETNA	94.3	91.5	605,275	73.1	73.6	64.7	0.5	1.1
NEW MEXICO	93.2	92.8	140,509	69.3	70.6	51.8	0.6	1.2
OKLAHOMA	94.7	91.1	464,766	74.3	74.6	70.1	0.5	1.1
TEXAS B/S	95.7	97.8	3,033,534	79.7	81.2	48.2	0.1	4.1
MARYLAND	96.5	103.0	621,127	80.8	81.9	48.3	0.1	5.3
TEXAS	95.5	96.5	2,412,407	79.5	81.0	48.2	0.1	3.8
DMERC-SC PGBA	93.2	107.5	1,088,040	83.1	87.4	24.0	0.2	0.3
KANSAS CITY REGION	94.1	98.4	2,058,935	77.3	78.2	62.6	0.4	0.8
IOWA B/S	92.8	101.3	475,474	79.5	80.8	63.1	0.0 *	1.1
KANSAS B/S	96.3	94.6	294,294	81.7	82.4	64.9	0.0 *	0.4
MISSOURI-KANSAS B/S	96.7	98.5	294,944	78.9	79.9	50.2	0.0 *	0.3
NEBRASKA-KANSAS B/S	88.7	96.2	213,412	71.8	72.0	69.9	0.0 *	0.5
MISSOURI-GENERAL AMERICAN	94.7	98.6	780,811	75.5	76.4	59.9	1.0	1.1
DENVER REGION	92.1	99.2	896,389	75.2	75.9	67.7	0.3	0.9
MONTANA B/S	95.4	98.9	120,006	71.6	72.2	58.7	0.9	0.7
NORTH DAKOTA B/S	90.6	101.1	630,171	76.3	77.2	67.5	0.1	0.9
COLORADO	94.2	101.6	349,967	73.1	74.2	56.1	0.1	1.1

* - LESS THAN 0.05 %

MEDICARE CLAIMS FLOW
PARTICIPATION STATISTICS

CARRIER	ASSIGN RATE	RATIO PROC/ REC'D	CLAIMS RECEIVED VIA ELECTRONIC MEDIA — TOTAL — NUMBER	TOTAL — PERCENT OF TOTAL CLMS RECEIVED	ASSIGNED — PERCENT OF ASS'D. CLAIMS RECEIVED	UNASSIGNED — PERCENT OF UNASS'D CLAIMS RECEIVED	REPLICATE CLAIMS — PERCENT OF TOTAL CLMS PROCESSED	CLAIMS INVEST RATE
NORTH DAKOTA	95.5	100.6	129,682	91.9	92.1	87.7	0.0 *	0.4
SOUTH DAKOTA	77.3	100.0	113,365	74.4	75.1	72.0	0.0 *	0.7
WYOMING	84.4	100.9	37,157	69.3	68.9	71.5	0.0 *	1.0
UTAH B/S	95.6	91.2	146,212	73.7	73.5	77.8	1.1	1.2
SAN FRANCISCO REGION	96.4	100.9	4,083,102	76.7	77.5	56.4	0.3	0.7
ARIZONA-NEVADA-AETNA	94.5	102.4	726,844	75.4	75.2	80.5	1.3	0.9
ARIZONA	93.2	102.3	562,172	77.8	77.4	83.0	1.2	0.8
NEVADA	98.3	102.7	164,672	68.4	68.7	49.7	1.6	1.2
CALIFORNIA B/S	95.2	99.1	1,467,092	73.7	75.2	45.6	0.0 *	1.0
OCCIDENTAL	98.1	101.3	1,787,540	80.4	81.0	51.0	0.1	0.3
HAWAII-AETNA	97.9	107.8	101,626	68.9	69.3	50.0	1.1	1.3
SEATTLE REGION	90.8	98.5	1,519,235	75.4	77.8	51.7	10.2	0.8
ALASKA-OREGON-AETNA	92.9	94.5	303,917	71.8	72.9	57.0	1.3	1.0
ALASKA	94.8	89.6	18,642	52.2	52.8	41.1	1.9	1.5
OREGON	92.7	94.9	285,275	73.6	74.8	58.1	1.3	1.0
IDAHO-CONN GEN	80.5	104.3	135,834	77.5	76.6	81.3	0.1	1.2
WASHINGTON-AETNA	94.7	94.5	614,518	76.0	76.6	66.1	25.7	1.2
DMERC-CONN GEN	87.1	105.0	464,966	76.6	83.7	28.6	0.1	0.1
RRB-METRAHEALTH	94.6	108.2	212,916	19.6	20.2	9.9	0.1	1.5
DMERC TOTAL	91.8	104.9	2,619,028	79.2	83.5	31.4	0.2	0.7
AETNA	95.2	95.3	3,399,022	73.9	74.4	64.6	5.4	1.1
CONN GENERAL (EXCL DMERC)	93.8	104.0	2,365,496	75.2	76.7	52.3	0.1	0.4
METRA(EXCL DMERC & RRB)	96.1	99.5	2,548,012	81.8	82.5	66.6	0.1	6.7
B/S PLANS	96.0	101.4	30,788,992	79.8	81.1	49.8	0.3	1.4

* - LESS THAN 0.05 %

MEDICARE CLAIMS FLOW

PARTICIPATION STATISTICS

Participation Statistics

	A	B	C	D	E	F
1		**PARTICIPATION RATES, BY STATE**				
2						
3						
4			JANUARY 1995		JANUARY 1996	
5		STATE	PCT PARTICIPATING		PCT PARTICIPATING	
6						
7		ALABAMA	90.50		91.80	
8						
9		ALASKA	77.10		73.50	
10						
11		ARIZONA	87.10		85.20	
12						
13		ARKANSAS	74.80		77.20	
14						
15		CALIFORNIA	74.50		80.50	
16						
17		COLORADO	65.20		79.50	
18						
19		CONNECTICUT	61.80		84.30	
20						
21		DELAWARE	68.00		72.20	
22						
23		DISTRICT OF COLUMBIA	63.00		65.30	
24						

MEDICARE CLAIMS FLOW
PARTICIPATION STATISTICS

	A	B	C	D	E	F
25		FLORIDA	68.00		70.90	
26						
27		GEORGIA	86.30		87.20	
28						
29		HAWAII	82.80		83.60	
30						
31		IDAHO	54.70		60.10	
32						
33		ILLINOIS	73.30		75.60	
34						
35		INDIANA	72.80		75.70	
36						
37		IOWA	81.10		83.60	
38						
39		KANSAS	84.40		91.10	
40						
41		KENTUCKY	83.40		85.80	
42						
43		LOUISIANA	57.40		61.00	
44						
45		MAINE	68.90		77.20	
46						
47						
48						

MEDICARE CLAIMS FLOW
NON FILING FILE REVIEW

	A	B	C	D	E	F
49		MARYLAND	88.10		89.90	
50						
51		MASSACHUSETTS	64.70		74.90	
52						
53		MICHIGAN	75.30		80.20	
54						
55		MINNESOTA	58.60		70.60	
56						
57		MISSISSIPPI	59.40		77.30	
58						
59		MISSOURI	87.60		86.80	
60						
61		MONTANA	70.10		77.40	
62						
63		NEBRASKA	82.50		86.30	
64						
65		NEVADA	91.20		90.80	
66						
67		NEW HAMPSHIRE	60.40		77.00	
68						
69		NEW JERSEY	54.90		60.60	
70						
71		NEW MEXICO	78.10		80.70	
72						

MEDICARE FLOW
CLAIMS FLOW
NON FILING FILE REVIEW

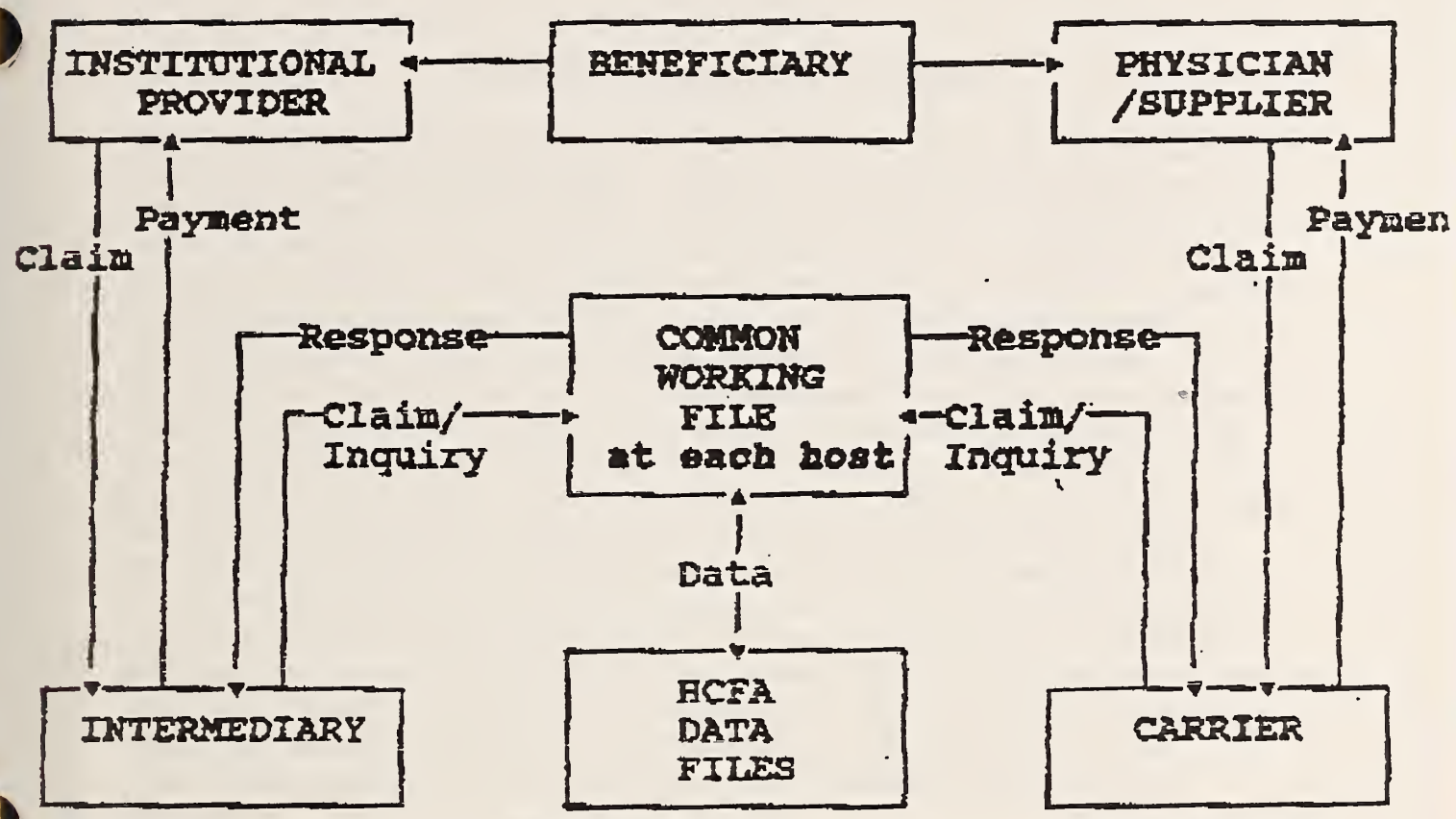
	A	B	C	D	E	F
73		NEW YORK	59.20		64.20	
74						
75		NORTH CAROLINA	77.60		81.00	
76						
77		NORTH DAKOTA	81.80		92.20	
78						
79		OHIO	90.50		91.80	
80						
81		OKLAHOMA	72.30		76.10	
82						
83		OREGON	79.70		82.10	
84						
85		PENNSYLVANIA	67.30		69.30	
86						
87		PUERTO RICO	70.70		84.30	
88						
89						
90						
91		RHODE ISLAND	80.90		66.80	
92						
93		SOUTH CAROLINA	76.10		82.70	
94						
95		SOUTH DAKOTA	51.70		71.40	
96						

MEDICARE ON
CLAIMS FLOW RING FILE

	A	B	C	D	E	F
97		TENNESSEE	80.60		83.10	
98						
99		TEXAS	76.90		80.30	
100						
101		UTAH	85.90		86.80	
102						
103		VERMONT	68.80		76.10	
104						
105		VIRGINIA	55.60		84.30	
106						
107		VIRGIN ISLANDS	32.70		40.00	
108						
109		WASHINGTON	76.20		86.40	
110						
111		WEST VIRGINIA	87.20		89.30	
112						
113		WISCONSIN	81.20		83.90	
114						
115		WYOMING	66.10		81.20	
116						
117						
118		NATIONAL TOTAL	72.30		77.50	
119						
120						

MEDICARE
CLAIMS FLOW
NON
RING FILE
REVIEW

MEDICARE CLAIMS FLOW



AS PROCESSING
- Receive,control, and key claims
- Review claims, edit, determine eligibility, coverage,pricing
- Write checks
- Explain pmt to provider & bene
- Update history & CWF files

BENEFICIARY SERVICES
PROVIDER RELATIONS
MEDICAL REVIEW
APPEALS
BANKING & PAYMENT
COMPILE STATISTICS
PROVIDER AUDIT
(Intermediary only)

ENTITLEMENT DATA
COMPILATION
NATIONAL CLAIMS
HISTORY DATA
MAINTENANCE
PROGRAM LIABILITY DATA
MAINTENANCE
STATISTICAL
COMPILATION

CLAIMS PROCESSING
- Receive , control, a key claims
- Review claims, edit, determine eligibility, coverag pricing
- Write checks
- Explain pmt to provi bene
- Update history & CWF files

BENEFICIARY SERVICES
PROVIDER RELATIONS
MEDICAL REVIEW
APPEALS
BANKING & PAYMENT
COMPILE STATISTICS

MEDICARE CLAIMS FLOW
HON RING FILE REVIEW

COMMON WORKING FILE OVERVIEW

The Common Working File system or better known as the CWF system is a pre-payment authorization claims processing system. There are nine CWF host processing sectors that house between 4 and 5.5 million beneficiary master records. A beneficiary master record is maintained at only one host and the Enrollment Database (EDB) at HCFA central office determines which host will maintain the beneficiary master record based on state code when the beneficiary first becomes entitled to Medicare. This method of assigning beneficiary master records has been in effect since December, 1991. Prior to that, as hosts were brought up into production mode and the satellites (intermediaries and carriers) transitioned to the CWF process, large blocks of beneficiary master records were requested from the HI master record system (predecessor of the EDB) based on the satellites claims activity. Once the satellites were in CWF production status, if a claim was received at the CWF host site that did not match a beneficiary master record, a request was submitted to the HI master system to either have the beneficiary master record assigned to that host or if the beneficiary master record was already assigned to another host, the HI master record system would send a record to the requesting host identifying the host that houses the beneficiary master record. This process is still in effect using the EDB. As far as I know, all beneficiary master records are now assigned and once a host receives a pointer record, all claims received from that time on are automatically forwarded to the host that houses the beneficiary master record for processing.

The Enrollment Database or EDB as it is better known, receives daily entitlement update records from SSA's Master Beneficiary Record (MBR) system. As the EDB processes these updates, the system creates an update file for each of the nine CWF host sites with the entitlement information that includes the beneficiary's address or representative payee name and address, date of death if present, part A and part B entitlement dates, effective and termination dates as applicable, and numerous data indicators. The EDB is also updated with Managed Care information from the Managed Care system within HCFA and that information is also passed to the CWF host sites. These updates are sent daily Monday through Friday, and are processed daily by all nine host sites.

The CWF satellites submit all claims and ESRD (end-stage-renal-disease), MSP (Medicare secondary payor), CMN (certificate of medical necessity) transactions to the host site in their CWF sector on a daily basis. CWF ensures that the claim or transaction is consistently correct which includes relationship edits based on data within the claim, that the beneficiary is entitled and has enough benefits available to cover the claim, and also performs limited duplicate check edits based on same claim type and also across claim type. The latter is done to ensure that the same service is not billed on more than one claim type. If a claim does not pass an edit and it is deemed critical, the claim is rejected and a response is returned to the satellite with a disposition code, error code and one or more trailers that contain information necessary to either correct the claim or explain why the claim was rejected. If the failed edit is deemed not critical, the claim is processed as an accepted claim and the response is returned to the satellite with an accept disposition code and one or more trailers with pertinent data. If an alert code is also returned, the

COMMON WORKING FILE OVERVIEW

alert code explains that there may be a problem but the claim was accepted and posted to CWF claim history and updated the benefits remaining (utilization) and any cash or blood deductible applied.

All claims accepted and posted to the CWF claims history and utilization are also passed in full claim format (all data received from the satellite plus data added by the CWF system) is passed to the National Claims History Database system in HCFA central office. The front end of that system is a quality assurance system and that system replicates all the edits that CWF maintains to insure the accuracy of the CWF system.

There are two online inquiry systems that CWF maintains. The first is called the Health Insurance Master Record (HIMR) system and is the most extensive inquiry system in CWF. This inquiry system allows HCFA central office and regional office components, the CWF maintenance contractor, the CWF host sites and all CWF satellites (intermediaries and carriers) access to the beneficiary master records, all beneficiary auxiliary records, the beneficiary master claims history, and the Clinical Laboratory Improvement Act (CLIA) master file, the mammography certification master file, and on 7/1/96, the HCFA Common Procedure Coding System (HCPCS) table (this table is maintained using a copy of the HCPCS master file distributed the end of each year and is constantly being changed during the year as changes are made to the HCPCS master file).

The second online inquiry system is used by intermediaries to get entitlement and utilization information to return to the providers querying their system. This information is limited in nature because of the Privacy Act. This system will return either screen formatted data or a machine readable block of data. This data includes both the part A and part B entitlement effective and termination dates as well as HMO/GHO data, date of death if present and some MSP data.

There is also a batch system that will accept requests for part B entitlement data and part B deductible status and HMO/GHO data from the carriers based on requests they receive from the physicians/suppliers that are on assignment and bill electronically. Once CWF receives these requests, the carrier number is maintained on the beneficiary master file (up to 10 carrier numbers) and any changes to the information is automatically sent to the carrier(s) that requested it. The carriers are suppose to maintain a inquiry beneficiary database for those beneficiaries they had requested.

The CWF system also has a claims history archival retrieval system that will allow removing claims from the full claims history file based on type of claim and service date. The claims removed are placed on non-DASD electronic media and is available off-line for retrieval back to the full claims history for on-line access. However, at the current time, the hosts are only required to keep the last archived file for retrieval purposes. The only types of claims archived in the normal archival process have been intermediary submitted outpatient claims and carrier submitted part B claims. However, other types of claims have been archived in another process known as a mini purge. This mini purge is only done when the number of history pointers for that particular type of claim has

reached the maximum number allowed on the beneficiary master record and the system is unable to process any more of those types of claims for that beneficiary. Both the regular archival process and the mini purge process can only be done after the host has requested and received permission to do one of those two processes.

The hosts were informed in November, 1994 to retain all archival files they currently have and any future archival files they will create, indefinitely. They were told to do this because HCFA did not know whether or not the MTS system would need these history claims.

THIS IS NOT A BILL

Explanation of Your Medicare **Part B** Benefits

JOHN D DOE
63 WOODLAWN DRIVE
APARTMENT 12C
BALTIMORE MD 21207-1111

Summary of this notice dated July 1, 1994		
Total charges:	$	170.00
Total Medicare approved:	$	44.65
We paid your provider:	$	35.71
Your total responsibility:	$	8.94

Your Medicare number is: 123-45-6789A

Your provider accepted assignment

Details about this notice (See the back for more information.)

BILL SUBMITTED BY: ELM STREET CLINIC
Mailing address: 123 ELM STREET BALTIMORE MD 21228

Dates	Services and Service Codes	Charge	Medicare Approved	See Notes Below
	Control number: 0000-0000-00000			
	MARY SMITH M.D.			
June 19-June 25, 1994	5 Chest x-ray [71010-26] Professional Charge	$ 170.00	$ 44.65	a

Notes:

a approved amount is based on the fee schedule.

GENERAL INFORMATION ABOUT MEDICARE:

The flu season is approaching. Now is a good time to make plans for your annual flu shot. Please remember that flu shots are now covered by Medicare.

Here's an explanation of this notice:

Of the total charges, Medicare approved	$	44.65	Your provider agreed to accept this amount. See #4 on the back.
Your 20%	-	8.94	We pay 80% of the approved amount; you pay 20%.
The 80% Medicare pays	$	35.71	**You have already met the deductible for 1994.**
Medicare owes	$	35.71	
We are paying the provider	$	35.71	
Of the approved amount	$	44.65	
Less what Medicare owes	-	35.71	
Your total responsibility	$	8.94	The provider may bill you for this amount. If you have other insurance, the other insurance may pay this amount.

IMPORTANT: If you have questions about this notice, call (carrier name) at (carrier telephone number) or see us at (carrier walk-in address). You will need this notice if you contact us.

To appeal our decision, you must WRITE to us before January 1, 1995. See #2 on the back.

Important Information You Should Know About Your Medicare Part B Benefits

This part of the notice answers some questions about receiving Medicare payments. If you have other questions, see your copy of *The Medicare Handbook* or call us for more information.

1. **What should I do if I have questions about this notice?**

   If you have questions about this notice, call, write, or visit us and we will tell you the facts that we used to decide what and how much to pay. Turn to the front of this notice; our address and phone number are on the bottom of the page.

2. **Can I appeal how much Medicare paid for these services?**

   If you do not agree with what Medicare approved for these services, you may appeal our decision. To make sure that we are fair to you, we will not allow the same people who originally processed these services to conduct this review.

   However, in order to be eligible for a review, you must **write** to us within **6 months** of the date of this notice, unless you have a good reason for being late (for example, if you had an extended illness which kept you from being able to file on time).

   Turn to the front of this notice; the deadline date and our address are on the bottom of the page. It may help your case if you include a note from your doctor or supplier (provider) that tells us what was done and why.

   If you want help with your appeal, you can have a friend, lawyer or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

3. **How much does Medicare pay?**

   The details on the front of this notice explain how much Medicare paid for these services. See your copy of *The Medicare Handbook* for more information about the benefits you are entitled to as a beneficiary in the Medicare Part B program. If you need another copy of the handbook, call or visit your local Social Security office.

   Medicare may make adjustments to your payment. We may reduce the amount we pay for services by a certain percentage (Balanced Budget Law). If your provider accepted assignment, you are not liable to pay the amount of this reduction. We pay interest on some claims not paid within the required time.

   All Medicare payments are made on the condition that you will pay Medicare back if benefits are also paid under insurance that is primary to Medicare. Examples of other insurance are employer group health plans, automobile medical, liability, no fault or workers' compensation. Notify us immediately if you have filed or could file a claim with insurance that is primary to Medicare.

4. **How can I reduce my medical costs?**

   Many providers have agreed to be part of **Medicare's participation program.** That means that they will always accept the amount that Medicare approves as their full payment. Write or call us for the name of a participating provider or for a free list of participating providers.

   A provider who accepts assignment for covered services can charge you only for the part of the annual deductible you have not met and the copayment which is 20 percent of the approved amount.

   If you are treated by one of these doctors, you can save money. See *The Medicare Handbook* for more information about how you can reduce your medical costs.

   Generally a doctor who has not accepted assignment may not charge more than 120 percent of the Medicare approved amount for services provided in 1992, or more than 115 percent for services provided in 1993 or later. This is known as the **limiting charge.** Contact us if assignment was not accepted, and you think your doctor charged more than the limiting charge.

5. **How can I use this notice?**

   You can use this notice to:

   - Contact us immediately if you think Medicare paid for a service you did not receive;
   - Show your provider how much of your deductible you have met;
   - Claim benefits with another insurance company. If you send this notice to them, make a copy of it for your records.

Keep this notice for your records.

Health Care Financing Administration

NOTICE OF MEDICARE CLAIM DETERMINATION

INTERMEDIARY NUMBER, NAME AND ADDRESS

DATE

YOUR HEALTH INSURANCE CLAIM NO

SERVICES PROVIDED BY: *(Name and Address)*

PROVIDER NUMBER

TYPE OF SERVICES PROVIDED	DATE OF ADMISSION OR FIRST VISIT	NOTICE COVERS PERIOD	
☐ HOSPITAL ☐ SKILLED NURSING FACILITY		FROM	THROUGH
☐ HOME HEALTH AGENCY ☐ OTHER	INSURANCE ☐ HOSPITAL ☐ MEDICAL		

This concerns the services you received from the facility shown above. Medicare cannot pay for part of these services for the following reason:

IMPORTANT: SEE OTHER SIDE FOR AN EXPLANATION OF YOUR APPEAL RIGHTS AND OTHER INFORMATION. ▶

FORM HCFA-1955(C3) (8-91)

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